Medical Home Logic Model

Medical Home Expansion for Clients who are Aged, Blind or Disabled

Note: In this document, the term "client" means clients who are aged, blind or disabled

GUIDING PRINCIPLES *What we value:*	**INPUTS** *Resources needed:*	**ACTIVITIES** *With resources we can accomplish:*	**OUTPUTS** *With activities accomplished we can deliver:*	**OUTCOMES** *Expected successes over time:*
❖ Improved access, quality and coordination of health care and community services ❖ Involve the community and build partnerships among those serving our clients who are aged, blind or disabled ❖ Pilot at local level before expansion ❖ Service models will vary based on clients geographical location ❖ The local community will drive model ❖ Fund infrastructure development ❖ Plan and fund evaluation as part of the design and include measures to encompass these domains: clinical quality, patient experience and infrastructure ❖ Learn from past experiences	❖ Key components of a Medical Home ❖ Analysis of data to include information about health care disparity ❖ Guidelines for managing chronic illness using evidence based medicine ❖ Provider One implementation and stabilization ❖ Key infrastructure elements, e.g., Health Information Technology (HIT), patient navigators and care managers ❖ DSHS staff with expertise and leadership skills to implement the program ❖ Community programs that currently serve or could serve clients ❖ Stakeholders supportive of building a Medical Home program ❖ The Medical Home Leadership Network	❖ Establish patient advisory committee ❖ Partner with providers and community-based programs serving clients ❖ Patient directed care planning ❖ Hire patient navigators and care managers ❖ Clinic practice redesign, such as open access scheduling, 24 hour nurse hotline ❖ Phase-in selected Medical Home models ❖ Use best practices to identify clients for care management such as predictive modeling ❖ Evaluate pilot program(s) ❖ Health risk assessments prior to or soon after enrollment ❖ Educate clients about the health care system and treatment choices ❖ Provider feedback about quality measures	❖ Expanded primary care office hours beyond traditional office hours ❖ Documentation of patient's healthcare in registry or electronic health record ❖ Providers can access client's complete medical record ❖ Client/provider or family/ provider partnerships ❖ Client has an identifiable and accountable PCP ❖ Client has a written care plan, periodically reviewed and updated ❖ Client has no problem getting care or medical advice on weekends or evenings ❖ Client has assigned care manager ❖ Improved appointment wait times ❖ Effective and simplified provider communication	**SHORT TERM OUTCOMES (1-3 years)** ❖ Decrease ED visits ❖ Reduce hospitalizations for ambulatory care sensitive conditions ❖ Improved client and provider satisfaction ❖ Increase the number of PCP/clinic/systems that meet the definition of medical home ❖ Improved clinical indicators for disease states ❖ End-of-life care that values client choice ❖ Smoother transitions for clients changing Medicaid eligibility ❖ Increased continuity of care ❖ Increase use of Health Information Technology (HIT) **LONG TERM OUTCOMES (4-6 years)** ❖ Improve population health

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❖ Provide supports for primary care providers such as patient navigators, care managers and co-location of services ❖ Align Medical Home expansion with Blue Ribbon Commission vision and recommendations (E2SSB 5930) and with SSB 5093, the Children's Health Bill ❖ Traditional purchasing approaches may change ❖ Models will promote evidence based, integrated services ❖ Services will be accessible, compassionate, and culturally effective ❖ Integrated service settings strengthened to achieve state of the art care ❖ Clear and transparent communication ❖ Align Medical Home expansion with Institute of Medicine quality improvement principles ❖ Across agency and administration collaboration	❖ The Washington State Collaborative to Improve Health ❖ Defined and transparent services ❖ Plan for communication among community programs ❖ Provider network to serve clients who are aged, blind or disabled ❖ Patient navigators and care managers (desired skill - RN/social workers) ❖ Community-based client registry or electronic health record ❖ A payment system that supports enhanced payment for care management ❖ Primary care participation in practice improvement activities	❖ Client outreach through patient navigator and/or care manager ❖ Access and use telemedicine and expert medical consultation ❖ Appropriate use of interpreters and transportation services ❖ Client receives reminders for preventive screening and disease management ❖ Hospital and ED admissions and discharges reviewed ❖ Medications reviewed ❖ Care coordination activities include mental health, drug and alcohol services and long-term care ❖ Interventions to increase social supports for clients e.g., trusted community resources including faith based organizations, clubhouse, Senior Services, mentors, friends, etc. ❖ Defined Medical Home communication methods	❖ Clients receive reminders for preventive and disease management ❖ Clients have the opportunity and tools to be informed, activated consumers	❖ All clients have a medical home ❖ Clients have 24 hour access to needed supports ❖ Build a high quality, high performing health care system (BRC goal for 2012) ❖ Eliminate health care disparity based on race, gender or income (BRC goal for 2012) **IMPACT OUTCOMES (7-10 years)** ❖ Blue Ribbon Commission recommendations realized ❖ More efficient and effective use of health care dollars for clients who are aged, blind or disabled ❖ Improve the overall health or slow the health decline of clients who are aged, blind or disabled ❖ Decrease mortality/ decrease morbidity ❖ Improve quality of life indicators